

Appendix 6 Prior Authorization Request Form (PA/RF) Sample

MAIL TO: E.D.S. FEDERAL CORPORATION PRIOR AUTHORIZATION UNIT 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-0088				PRIOR AUTHORIZATION REQUEST FORM <div style="border: 1px solid black; padding: 2px; display: inline-block;">PA/RF</div> (DO NOT WRITE IN THIS SPACE)				1 PROCESSING TYPE <div style="border: 1px solid black; padding: 5px; display: inline-block; width: 60px;">118</div>	
2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890				4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Anytown, WI 55555					
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Ima A.									
5 DATE OF BIRTH MMDDYY		6 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		8 BILLING PROVIDER TELEPHONE NUMBER (XXX) XXX-XXXX					
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: IM Provider 1 W. Williams Anytown, WI 55555				9 BILLING PROVIDER NO. 12345678					
				10 DX: PRIMARY 893.2 Subluxation of lumba 11 DX: SECONDARY 839.00 Subluxation of cervica					
12 START DATE OF SOI:				13 FIRST DATE RX:					
14	15	16	17	18	19	20			
PROCEDURE CODE	MOD	POS	TOS	DESCRIPTION OF SERVICE	OR	CHARGES			
W9010		3	1	Chiropractic adjustment	12	XX.XX			
22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.					TOTAL CHARGE	21 XX.XX			
23 MMDDYY DATE		24 <i>J. B. Provider</i> REQUESTING PROVIDER SIGNATURE							

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION: <input type="checkbox"/> APPROVED <input type="checkbox"/> MODIFIED — REASON: <input type="checkbox"/> DENIED — REASON: <input type="checkbox"/> RETURN — REASON:	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> GRANT DATE	<div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div> EXPIRATION DATE	PROCEDURE(S) AUTHORIZED QUANTITY AUTHORIZED
--	---	--	--

DATE

 CONSULTANT/ANALYST SIGNATURE